

Illinois Department of Healthcare and Family Services

LONG TERM CARE FACILITY NOTIFICATION

TO:

FROM:

Client Name: _____ Recipient Number: _____ Case Number: _____

SSN: _____ Social Security Claim #: _____ Birthdate: _____

1. ☐ **ADMISSION**

Admission Date: _____ From: Hospital ☐ Community ☐ SLF ☐ Other LTC Facility ☐

Previous Address: _____

Client receives or will receive hospice services Yes ☐ No ☐

Admitting Diagnosis (ICD-9 Code): _____

Attending Physician Name: _____ Attending Physician Number: _____

Level of Care (Check One): ____SNF ____ICF ____ICF/MR ____SLF

2. ☐ **DISCHARGE**

Discharge Date: _____

To: Community ☐ Other LTC Facility ☐ SLF ☐ General Hospital ☐ State-Operated Facility ☐

Left State/County ☐ Unknown ☐ CILA ☐ Other ☐ _____

New Address: _____

3. ☐ **DEATH**

Date of Death: _____ Body Released To: _____

4. ☐ **COMPLETE THIS SECTION ONLY WHEN REPORTING A DISCHARGE OR DEATH**

☐ Personal Funds Balance on the Day of Discharge or Death: _____

☐ Amount of Other Funds on the Day of Discharge or Death: _____

☐ Room & Board Balance on the Day of Discharge or Death: _____

☐ Funds were Given to: Client ☐ Relative ☐ Administrator of Estate ☐ Other ☐

Name/Relationship/Address: _____ Amount: _____

5. ☐ **MEDICARE (Check as appropriate)**

☐ Full Medicare Covered SNF Services: Begin Date: _____ End Date: _____

☐ Medicare Coinsurance: Begin Date: _____ End Date: _____

6. ☐ **INSURANCE COVERAGE (TPL)**

(e.g. name of company, change in coverage, change in premium):

SEE REVERSE

7. ☐ RECEIPT OF LONG TERM CARE INSURANCE (TPL) PAYMENT

Date Received: _____ Amount: _____ Dates Covered by Payment: _____
Date and Amount of TPL Funds, if any, Returned to Client: Date: _____ Amount: _____
Date and Amount of Group Care Credit Funds, if any, Returned to Client: Date: _____ Amount: _____

8. ☐ INCOME (Check as appropriate)

☐ Change in Income: Previous Monthly Amount: _____ Date Last Received: _____
Current Monthly Amount: _____ Date First Received: _____
Source: _____
☐ Receipt of Income: Monthly Amount: _____ Source: _____
Date First Received: _____
☐ Receipt of Lump Sum: Amount: _____ Source: _____ Date Received: _____

9. ☐ REMARKS

DPA 26 Attached: Yes ☐ No ☐

DPA 2536 Attached: Yes ☐ No ☐

Signature/Title: _____ Date: _____

INSTRUCTIONS FOR COMPLETION

PURPOSE: The HFS 1156 is used by the LTC or SLF facility to notify the Department of Human Services (DHS) local office of admission, discharge, death or other changes in circumstances of a client which could have an effect on continuing eligibility. When changes in the client's circumstances occur, this notice must be forwarded to the DHS local office within five days of the change. Since reserve bed days do not affect eligibility, it is not necessary to complete this form to report absences for hospitalization or therapeutic home visits.

FORMS COMPLETION: The form is completed in duplicate with the original to the appropriate DHS local office and the copy retained by the facility.

TO: Enter name of DHS local office.

FROM: Enter facility name and address.

General Information: Self-explanatory.

1. Check if reporting a new admission. Enter all information for this item.
2. Check if reporting a discharge. Enter all information for this item.
3. Check if reporting a death. Enter all information for this item.
4. Check as appropriate when reporting a discharge or death. Enter all information for this item. Do not delay submittal of this form because the client's funds have not been disbursed. Enter the balance of funds on the day of discharge or death. If none, enter "0". Enter name/relationship/address of persons to whom funds were given and the amount disbursed. Enter "0" if the funds have not been disbursed as of the date the form is completed.
5. Check if reporting a change to or from Medicare coverage. Enter all information for this item.
6. Check if reporting new insurance coverage or a change in existing coverage.
7. Check if reporting receipt of long term care insurance coverage.
8. Complete if reporting a change in the client's income. Complete upon receipt of information or as changes occur. Check as appropriate and enter necessary information.
9. This section is completed to convey additional information for which no other space is provided on the form (e.g., funds in excess of \$2000). Complete as needed.

The form must be signed and dated by the person to whom the facility has assigned the responsibility for reporting changes in a client's circumstances.